South Carolina Department of Labor, Licensing and Regulation
Board of Medical Examiners
Synergy Business Park, Kingstree Building
110 Centerview Drive
Post Office Box 11289
Columbia, SC 29211
(803) 896-4500

APPLICATION FOR A SPECIAL 14 DAYS LIMITED LICENSE

A special limited license may be issued to a physician licensed in another state for up to fourteen days not more than four times a year in order to authorize practice under supervision for training involving direct patient care or to explore potential employment relationships. Complete all sections of this application by providing all of the requested information, non refundable application fee of $75.00 and documentation from the supervising physician relating the purpose and dates requested sent directly to the Board. This application form is a public document obtainable under the Freedom of Information Act.

PART I: Applicant Identifying Information

1. **Last Name**	2. **First Name**	3. **Middle Name**	4. **Suffix (Jr., III)**
5. **Title** ☐ M.D. ☐ D.O.	6. **Maiden Name**		
7. **Mailing Address** (Street or PO Box, City, State, Zip)			
8. **Home Address** (Street, City, State, Zip – not PO Box)			8a. **Home Congressional District**
8b. **Home Phone**	8c. **Home Fax**	8d. **Home Email**	
9. **Business Name**	9a. **Business Address** (Street, City, State, Zip – not PO Box)		
9b. **Business Phone**	9c. **Business Fax**	9d. **Business Email**	
10. **Place of Birth** (List City & State or Country)	11. **Date of Birth** MM/DD/YYYY	12. **Gender** ☐ Male ☐ Female	13. **Race (For Statistical Purposes Only)** ☐ African American/Black ☐ American Indian ☐ Asian/Oriental ☐ Hispanic/Spanish Origin ☐ Caucasian/White ☐ Other

PART II: Education Information

SCHOOL NAME	LOCATION (City, State & Country)	DATES OF ATTENDANCE FROM (Month/Year)	DATES OF ATTENDANCE TO (Month/Year)	GRADUATED Yes/No	HIGHEST GRADE COMPLETED OR DEGREE EARNED

Professional Education

List in chronological order from date of graduation to the present all professional education. Do not include continuing education coursework, apprenticeship, intern, residency, vocational training practical or clinical training.

INSTITUTION NAME	LOCATION (City, State & Country)	DATES OF ATTENDANCE FROM (Month/Year)	DATES OF ATTENDANCE TO (Month/Year)	DID YOU COMPLETE PROGRAM	DEGREE EARNED
				Y ☐ N ☐	
				Y ☐ N ☐	
				Y ☐ N ☐	
				Y ☐ N ☐	

*The Social Security Number (SSN) is not subject to disclosure as public information. The disclosure of the SSN for identification purposes is authorized and mandated by federal statutes requiring state boards to report to the Healthcare Integrity and Protection Data Bank (HIPDB) and the National Practitioner Data Bank (NPDB), among other things. (Revised 7/10/12)

Are you a graduate from a program outside the United States?	**YES ☐ NO ☐**
Was your medical education interrupted other than for vacation periods? If yes, attach a written explanation.	**YES ☐ NO ☐**

PART III: Internship and Residency Training Information

Complete the requested information below on all training programs completed in the US or Canada. Failure to disclose any training program information may result in the denial of your application or other appropriate action.

SCHOOL NAME	LOCATION (City, State & Country)	DATES OF ATTENDANCE		GRADUATED Yes/No
		FROM (Month/Year)	TO (Month/Year)	

PART IV: Record of Examination(s)

Complete the requested information below if licensure examination was taken in this state or any other state. List each examination attempt below, use additional sheets if necessary. Failure to disclose an examination attempt may result in the denial of your application or other appropriate action.

Name of Examination(s)	State or Country	Date of Examination	Passed/Failed/Score (If score, enter score)

PART V: Record of Licensure

Complete the requested information below if you have ever been licensed to practice in any profession or occupation. You must identify the method by which you obtained your license(s) and include jurisdiction both within and outside the United States current or inactive. Failure to disclose all licenses held may result in denial of your application or other appropriate action. (Attach additional sheets if necessary.)

Jurisdiction	Credential Type (MD or DO)	License Number/Name on License	How License Obtained (Type of Exam or Endorsement)	Date issued
State of Original (Initial) Licensure:				
List Other Jurisdictions of Licensure:				

PART VI: Medical Specialty and South Carolina Location Information

1. Current medical specialty/training:_____

2. Expected South Carolina practice location:_____
Hospital/Clinic Name

_____
Street Address City State Zip

Office telephone no.:_____ Effective dates:_____

3. Certified/recertified by American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA):

Board name:_____Year:_____
Attach copies of American Specialty Board Certificates (ABMS or AOA)

4. Branch of military service:_____date of service:_____type of discharge:_____
Attach a copy)

PART VII: Medical Practice/Employment History

List all related employment chronologically most recent first, for the past five (5) years. If you have never been employed in the profession you are applying for, insert "N/A" for Not Applicable. Photocopy this form if additional space is required.

1. Company Name	**Company Address (Street, City, State, Zip)**	
Job Title	**Type of Employment** ☐ **Full -time** ☐ **Part-Time**	**Date of Employment** **From:** _____ **To:** _____
Abbreviated Description of Duties Performed	**Hours Worked per Week**	**Reason for leaving**
2. Company Name	**Company Address (Street, City, State, Zip)**	
Job Title	**Type of Employment** ☐ **Full -time** ☐ **Part-Time**	**Date of Employment** **From:** _____ **To:** _____
Abbreviated Description of Duties Performed	**Hours Worked per Week**	**Reason for leaving**
3. Company Name	**Company Address (Street, City, State, Zip)**	
Job Title	**Type of Employment** ☐ **Full -time** ☐ **Part-Time**	**Date of Employment** **From:** _____ **To:** _____
Abbreviated Description of Duties Performed	**Hours Worked per Week**	**Reason for leaving**

PART VIII: Personal History Information

If you answer "**yes**" to any of the questions below (1-15), you must attach a full written explanation pertaining to that particular question.

1. Has your medical license ever been revoked, suspended, reprimanded, restricted or placed on probation by a Medical Licensing Board or other entity?	**YES** ☐ **NO** ☐
2. Have you ever had an application to practice medicine denied or refused by another Medical Licensing Board or other entity?	**YES** ☐ **NO** ☐
3. Have you ever had any hospital privileges denied, revoked, suspended or restricted in any way?	**YES** ☐ **NO** ☐
4. Have you ever voluntarily surrendered a medical license, controlled substance registration or DEA registration?	**YES** ☐ **NO** ☐
5. Have you ever resigned from any hospital, institution or health care facility in lieu of disciplinary action?	**YES** ☐ **NO** ☐
6. Are you currently under investigation or the subject of pending disciplinary action by any Medical Licensing Board, health care facility or other entity?	**YES** ☐ **NO** ☐
7. Is your medical license currently restricted in any way by any Medical Licensing Board, or other entity?	**YES** ☐ **NO** ☐
8. Have you ever had a malpractice lawsuit, judgment or settlement filed against you? If yes, how many? _____ (Complete the attached malpractice claim form, if applicable)	**YES** ☐ **NO** ☐
9. Currently or within the last ten years, have you been treated for any physical, mental or emotional condition that might interfere with your ability to competently and safely perform the essential functions of practice as a physician?	**YES** ☐ **NO** ☐
10. Currently or within the last ten years, have you developed any disease or conditions, physical, mental or emotional, (e.g. bipolar disorder, schizophrenia, paranoia, or any other psychotic disorder) that might interfere with your ability to competently and safely perform the essential functions of practice?	**YES** ☐ **NO** ☐
11. Has your ability to practice medicine ever been impaired by any physical or mental illness or by the use of alcohol or drugs?	**YES** ☐ **NO** ☐
12. Have you ever discontinued the practice of medicine for any reason for one month or more?	**YES** ☐ **NO** ☐
13. Has your ability to prescribe controlled substances ever been denied, revoked, suspended, or limited by any hospital, health care facility or other entity?	**YES** ☐ **NO** ☐
14. Currently or within the last ten years, have you been arrested, indicted, or convicted, pled guilty, or pled nolo contendere for violation of any federal, state, or local law (other than a minor traffic violation)?	**YES** ☐ **NO** ☐
15. Have you ever been known by any other name or surname?	**YES** ☐ **NO** ☐

PART XII: Certifying Statement

I, _____ being duly sworn, depose and say that I am the person described and identified, that I am of good moral character and that I am the person named in the documents presented in support of this application. By filing this application, I hereby authorize and consent to an investigation of my fitness and qualifications to practice medicine in South Carolina.

I hereby authorize all hospitals, medical institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state and federal) to release to this licensing Board any information, files or records requested by the Board for its evaluation of my professional, ethical and other qualifications for licensure in South Carolina. I hereby release, discharge and exonerate the State Board of Medical Examiners of South Carolina, its agent or representative and any person or organization furnishing information from any and all liability of every nature and kind arising out of the furnishing of documents, records or other information, or arising from the investigation made by the State Board of Medical Examiners of South Carolina.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare that all statements made by me herein are true and correct. Should I furnish any false or incomplete information in this application, I hereby agree that such an act shall constitute the cause for denial or revocation of my license to practice medicine in South Carolina. Further, if licensed, I agree to keep the Board informed of any future changes in my address.

I hereby authorize the Board of Medical Examiners of South Carolina to utilize my Social Security Number in making necessary reports to the Federation of State Medical Boards' Physician Data Center for compilation of information about applicants and licensees in order to coordinate licensure and disciplinary activities between the individual States' licensing boards.

_____
Signature of Applicant (Do not print)

_____
Printed Name of Applicant

_____
Date

Subscribed and sworn to before me this _____ day of

_____, _____.

_____
Notary Public Signature

My Commission Expires: _____

Attach professional photo here

(2x2)
Passport size

No copies

Do Not Staple

RIGHT THUMB PRINT
If right thumb is missing, use left and so indicate

For Office Use Only

Date Received: _____

Paid by: ☐Check ☐Money Order ☐ Cash

Check/Money Order No: _____ Amount: _____

Control No. _____ Deposit No. _____

AFFIDAVIT OF ELIGIBILITY

Pursuant to section 8-29-10 of the South Carolina Code of Laws (1976 as amended), the Department of Labor, Licensing and Regulation must verify the lawful U.S. presence of any person who applies for a South Carolina license. Please complete and sign this affidavit of eligibility. The information provided is subject to verification.

Section A: LAWFUL PRESENCE in the United States.

I, (please print your full name) _____, swear or affirm under penalty of perjury under the laws of the State of South Carolina that (check 1, 2 or 3 below):

1. ___ I am a United States citizen or legal permanent resident eighteen years of age or older; or

2. ___ I am not a US citizen but am lawfully present in the US as evidenced by one of the following
   a. ___ I am a qualified alien as defined in 8 U.S.C. sec 1641, eighteen years of age or older.
   b. ___ I am a nonimmigrant under the "Immigration and Nationality Act," Federal Public Law 82-414 as amended, eighteen years of age or older.

3. ___ I am not physically present in the US under 8 U.S.C. sec 1621 (c) (2) (c) or employed in the US pursuant to 8 U.S.C. 1621 (c) (2) (a) (check either a or b below):
   a. ___ I am a US citizen, not physically present or employed in the United States.
   b. ___ I am a Foreign National, not physically present or employed in the United States.

If you selected either 3.a. or 3.b., you do not need to complete Section B. Skip to Section C.

Section B: Secure and Verifiable Document. This section must be completed if you checked number 1 or 2 in Section A.

1. Please check one of the following acceptable secure and verifiable documents. Complete documentation must be provided.

☐ Any valid South Carolina Driver's License, South Carolina Driver's Permit or South Carolina Identification Card? Number _____; Date of Expiration: _____

☐ Any valid out-of-state issued photo Driver's License or photo identification card, photo driver's permit? State: _____; Number_____; Date of Expiration: _____.

☐ Permanent Resident Card; Alien Number _____; Card Number _____; Date of Expiration: _____.

☐ Employment Authorization Card; Alien Number _____; Card Number _____; Date of Expiration: _____

☐ Certificate of Naturalization with intact photo.

☐ Certificate of (US) Citizenship with intact photo.

☐ Other: (Name of verifiable document) _____

2. Enter the state or the federal agency name where this secure and verifiable document was issued.

_____
(If issued by a state agency, include both the state and agency name.)

3. Please provide your social security number: _____/_____/_____

Section C: Attestation.

- I understand that this sworn statement is required by law because I have applied for or seek reinstatement of a professional or commercial license as provided for in 8 U.S.C. §1621. I understand that state law requires me to provide proof that I am lawfully present in the United States.
- I understand that in accordance with section 8-29-10 of the South Code, a person who knowingly and willfully makes a false, fictitious, or fraudulent statement or representation in an affidavit shall be guilty of a felony.
- I am the person identified above, and the information contained herein is true and correct to the best of my knowledge. I understand that under South Carolina law, providing false information is grounds for denial, suspension or revocation of a license, certificate, registration or permit.

_____ _____
Signature Date

_____
Please print your name as shown on your secure and verifiable document.

Professional License Type: _____

License Number (if already licensed): _____

The South Carolina Law requires that every individual who applies for an occupational or professional license provide a social security number for use in the establishment, enforcement and collection of child support obligations and for reporting to certain databanks established by law. Failure to provide your social security number for these mandatory purposes will result in the denial of your licensure application. Social security numbers may also be disclosed to other governmental regulatory agencies and for identification purposes to testing providers and organizations involved in professional regulation. Your social security number will not be released for any other purpose not provided for by law.

06/28/12 Affidavit of Eligibility

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MALPRACTICE CLAIM INFORMATION

This form must be completed if you have ever been named as a defendant in a malpractice lawsuit, verdict or settlement.

_____

Physician name Office telephone no.

_____

Address City State Zip

MALPRACTICE COMPLAINT: (Include name of patient, age, sex, date of occurrence and location, i.e., office or name and address of hospital.)

Patient's Name: _____

Age: _____ Sex: _____

Date/place of occurrence:_____

Indicate your position in case, i.e., resident, primary physician, etc.: _____

_____

_____

FILED AGAINST: ( ) Individual Doctor ( ) Group ( ) Hospital
List names of other defendant-doctors and/or hospitals:

_____

_____

DISPOSITION: ( ) Pending ( ) Jury Verdict ( ) Settled ( ) Dismissed ( )Dropped
If there has been a verdict or settlement, please provide the following information:

Legal outcome: _____

Date: _____ Total amt. paid (if any): _____

Amount attributable to you: _____

1. On a separate sheet, provide a detailed written explanation of the background and medical issues involved in the case.
2. Attach copies of the complaint, answer, release, settlement documents and all other relevant legal documents.
3. Form may be duplicated as needed. A separate report must be completed for each malpractice claim.

Date: _____ Signature: _____

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VERIFICATION OF LICENSURE

Complete the top portion of this form and forward a copy to each state board by which you are now or ever been licensed to practice medicine. You may want to contact each state to see if a fee is required.

In applying for a license to practice medicine in the State of South Carolina, the Board of Medical Examiners requires this form to be completed by each state wherein I hold or have ever held a license. My signature below is your authority to release any and all information in your file, favorable or otherwise, regarding me directly to the above address.

PLEASE TYPE OR PRINT

Signature _____

Name _____

Address _____

_____

City State Zip

DO NOT DETACH

This section should be completed by an official of the state board and returned directly to the South Carolina Board of Medical Examiners.

Full name of licensee: _____

Graduate of: _____Date of degree: _____

State of: _____ License number: _____ Date issued: _____

Licensed by: ( ) National Board ( ) FLEX Exam ( ) USMLE
( ) State Board Exam ( ) Other_____

License is current_____ If no, why not? _____

Has license been suspended, revoked, or restricted?_____ If yes, why? _____

Comments, if any_____

_____

Date: _____ Signature: _____

Board Seal Title: _____

State Board: _____